31. Federally Qualified Health Centers. (Continued)

(17) Any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount.

(18) Mileage expense exceeding the current reimbursement rate set by the Texas Legislature for state employee travel.

(19) Cost for goods or services which are purchased from a related party and which exceed the original cost to the related party.

(20) Out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses which increase the quality of medical care and/or the operating efficiency of the FQHC.

(21) Over-funding contributions to self-insurance funds which do not represent payments based on current liabilities.

(22) Overhead costs beyond the limitations established by the state agency.

32. EPSDT DIAGNOSTIC AND TREATMENT SERVICES NOT OTHERWISE COVERED UNDER THE STATE PLAN

Except as otherwise specified, payment for authorized medically necessary services required to diagnose and treat a condition under EPSDT will be based on existing Medicare and/or Medicaid reimbursement methodologies.

32. Continued.

Reimbursement for expendable medical supplies.

(A) The single state agency or its designee makes payments to suppliers of expendable medical supplies. Suppliers are reimbursed within the limits defined by the maximum allowable fee schedule for expendable medical supplies established by the single state agency. The maximum allowable fee schedule is based upon the lesser of the following:

(i) the billed amount, or;

(ii) the Medicare Fee Schedule, as defined in subparagraph (B)(i) of this paragraph; or

(iii) expendable medical supplies acquisition fee, ad defined in subparagraph (B)(ii) of this paragraph.

(B) The following words and terms, when used in this section shall have the following meanings, unless the context clearly indicates otherwise.

(i) Medicare Fee Schedule - the fee schedule established by the Medicare Program for expendable medical supplies.

(ii) Expendable medical supplies acquisition fee - The fee determined by the single state agency or its designee by periodic sampling of suppliers or from information provided in manufacturer's publications, whichever is the lesser amount.

(iii) Expendable medical supplies - Medical supplies which meet one or both of the criteria specified in subclauses (l) and (ll) of this clause:

(l) the typical term of use is within one year of purchase, and/or

(ll) reimbursement is made at a cost of $1,000 or less.

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32. Continued.

Reimbursement for durable medical equipment.

(A) The single state agency or its designee makes direct vendor payments to providers of durable medical equipment participating in the Medicaid program. Participating providers are reimbursed within the limits of the maximum allowable fee schedule established by the single state agency or its designee. The maximum allowable fee schedule for durable medical equipment is based on the lesser of the following:

(i) The billed amount; or

(ii) the Medicare fee schedule, as defined in subparagraph (B)(ii) of this paragraph; or

(iii) the durable medical equipment acquisition fee, as defined in subparagraph (B) (iii) of this paragraph; or

(iv) if no discount is provided, the actual cost to the dealer plus twenty-five percent.

(B) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(i) Durable medical equipment - Machinery and/or equipment which meets one or both of the criteria specified in subclauses (I) and (II) of this clause:

(I) the projected term of use is more than one year, and/or

(II) reimbursement is made at a cost of more than $1,000.

(ii) Medicare fee schedule - The fee schedule established by the Medicare program for durable medical equipment.

(iii) Durable medical equipment acquisition fee - Reimbursement for the acquisition of machinery or equipment based upon the manufacturer's suggested retail price, as defined in clause (iv) of this subparagraph, minus a weighted average discount, as defined in clause (v) of this subparagraph.

(iv) Manufacturer's suggested retail price - The listed price that the manufacturer recommends as the retail selling price for an individual piece of durable medical equipment.

(v) Weighted average discount - The weighted average percentage discount determined from the total discount that vendors receive from manufacturers. The initial value of the weighted average discount for fiscal years 1992 and 1993 is determined from historical payments and pertinent information provided by the Texas Department of Health. Thereafter, the single state agency or its designee is responsible for conducting a representative sample by which a weighted average discount is determined. Participating providers must, at the request of the single state agency or its designee, provide necessary information needed to determine the weighted average discount. The single state agency or its designee reviews the weighted average discount at least every two years.

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32. Continued.

Reimbursement for durable medical equipment.

(C) Ventilator service agreements. If the Medicaid client currently owns a ventilator, the single state agency or its designee may provide reimbursement for a service agreement, in accordance with the policy of the single state agency or its designee, and at the lesser of the billed amount or a rate determined by the single state agency or its designee. The single state agency or its designee will negotiate the ventilator service agreement rate on an individual case basis, based upon the needs of the client and the prevailing ventilator service agreement rates in the geographic area, not to exceed 80% of the rate charged to the general public by the provider with the highest rate in areas with multiple providers, and 100% of the rate charged to the general public in areas served by only one provider.

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32. Continued.

Private duty nursing. The single state agency or its designee makes payment to licensed vocational nurses and registered nurses according to the lesser of actual charge or a fee schedule established by the single state agency. The fee schedule established by the single state agency is determined from the hourly rate for nursing services provided in Title XIX nursing home facilities and translated directly into the facility daily rate.

32. Continued.

Occupational therapy. The single state agency or its designee makes payment to qualified occupational therapists according to the lesser of actual charge or a fee schedule established by the single state agency. The fee schedule established by the single state agency is based on Texas Medicaid Reimbursement Methodology (TMRM), which is a flat fee structure applicable on a statewide basis.

32. Continued.

Speech therapy. The single state agency or its designee makes payment to licensed speech pathologists according to the lesser of actual charge or a fee schedule established by the single state agency. The fee schedule established by the single state agency is based on Texas Medicaid Reimbursement Methodology (TMRM), which is a flat fee structure applicable on a statewide basis.

32. Continued.

Inpatient psychiatric services provided to EPSDT recipients in psychiatric facilities/programs, other than hospitals. The psychiatric facility/program must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The single state agency or its designee reimburses psychiatric facilities/programs using Medicare principles of reasonable cost reimbursement found at 42 CFR 413, but without applying the TEFRA rate of increase limits. EPSDT recipients will be given the free choice of qualified providers and the requirements of 42 CFR 441 Subpart D will be met.

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32. Continued.

Nutritional Services. The single state agency or its designee makes direct payment to licensed dietitians, on an hourly basis, according to the lesser of actual charge or a fee schedule established by the single state agency. The fee schedule established by the single state agency is determined from the hourly rate for nutritional services provided in Title XIX nursing home facilities for the 1992 rate period and translated directly into the facility daily rate. The single state agency has determined that this is a reasonable reimbursement for nutritional services to be provided by licensed dietitians. Medicaid benefits are for client nutritional services for the purpose of treating, preventing, or minimizing the effects of illness, injuries, or other impairments.

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